Health and welfare benefits

Prime - High Deductible Plan

2026 Premiums*

Prime - HDP	Full Time	Part Time
Employee Only	$20.00	$32.00
Employee + Spouse/ Domestic Partner	$78.00	$121.00
Employee + Child(ren)	$70.00	$109.00
Employee + Family	$125.00	$181.00

Choice – Medical Home Plan

2026 Premiums*

Choice - MHP	Full Time	Part Time
Employee Only	$47.50	$78.00
Employee + Spouse/ Domestic Partner	$141.50	$221.00
Employee + Child(ren)	$111.00	$174.00
Employee + Family	$233.50	$339.00

* Your medical, dental and vision premiums are deducted from the first two paychecks each month. 401(k) deductions are taken out of each paycheck.

Health and welfare benefits

Dental

You have the choice of a Dental only plan OR a Dental + Orthodontia plan to fit you and your family's needs. Preventative services (cleanings and regular exams) are covered 100% and the deductible does not apply.

Dental Only Plan

Network: Delta Dental Premier Network

Administrator: Delta Dental

Annual Deductible: $25 individual / $75 family

Basic Services: 80% after deductible

Major Services: 50% after deductible

2026 Premiums*

	Full Time	Part Time
Employee Only	$9.00	$15.00
Employee + Spouse/ Domestic Partner	$19.50	$32.50
Employee + Child(ren)	$22.50	$37.50
Employee + Family	$39.00	$65.00

Dental + Orthodontia Plan

Network: Delta Dental Premier Network

Administrator: Delta Dental

Annual Deductible: $25 individual / $75 family

Basic Services: 80% after deductible

Major Services: 50% after deductible

Orthodontia: 50% to lifetime maximum of $1,500 per person

2026 Premiums*

	Full Time	Part Time
Employee Only	$11.50	$19.00
Employee + Spouse/ Domestic Partner	$27.00	$45.00
Employee + Child(ren)	$31.00	$51.50
Employee + Family	$53.50	$89.00

* Your medical, dental and vision premiums are deducted from the first two paychecks each month. 401(k) deductions are taken out of each paycheck.

Health and welfare benefits

Vision

Employees have two vision plans to choose from, Vision Basic or Vision Premium. You can choose to get covered for the essentials with the Vision Basic Plan or upgrade to the new enhanced Vision Premium Plan with annual benefits, increased allowances for frame and contact lenses, and VSP LightCare.

Basic

Network: VSP Choice Network

Administrator: VSP

Copays

- Exams: $20 copay for in–network providers.
- Prescription lenses (single vision, bifocals, trifocals) $20 copay in-network.
- Standard progressive lenses - $0; Premium and custom available at a discounted rate.
- Contacts: Fit & Follow-up – up to $60 copay and contacts plan pays up to $170/calendar year for in – network

2026 Premiums*

	Full Time	Part Time
Employee Only	$3.26	$3.26
Employee + Spouse/ Domestic Partner	$5.97	$5.97
Employee + Child(ren)	$6.64	$6.64
Employee + Family	$9.08	$9.08

Premium

Network: VSP Choice Network

Administrator: VSP

Copays

- Exams: $10 copay for in–network providers.
- Prescription lenses (single vision, bifocals, trifocals) $20 copay in-network.
- Standard progressive lenses - $0; Premium and custom available at a discounted rate.
- Contacts: Fit & Follow-up – up to $60 copay and contacts plan pays up to $250/calendar year for in – network

2026 Premiums*

	Full Time	Part Time
Employee Only	$11.42	$11.42
Employee + Spouse/ Domestic Partner	$20.93	$20.93
Employee + Child(ren)	$23.25	$23.25
Employee + Family	$32.57	$32.57

* Your medical, dental and vision premiums are deducted from the first two paychecks each month. 401(k) deductions are taken out of each paycheck.